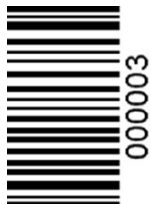




PENSION LIFE COVER FOR PERSONAL PENSION PLANS

DECLARATIONS

**Proposal Number:**

--	--	--	--	--	--	--	--

Customer Review Number

[illegible]

Name Life Assured 1

[illegible]

Financial Adviser Name

[illegible]

If you submit this proposal electronically you should only send us this section.

Any words in the singular also mean the plural as applicable (e.g. "I" means "we" and "my" means "our" etc.)

A. Declaration under regulation 6(3) of the Life Assurance (Provision of Information) Regulations 2001

WARNING

If you propose to take out this plan in complete or partial replacement of an existing plan, please take special care to satisfy yourself that this plan meets your needs. In particular, please make sure you are aware of the financial consequences of replacing your existing plan. If you are in doubt about this, please contact your insurer or insurance adviser.

Please complete this section by ticking the appropriate box:

This includes:
Canada Life
Progressive Life

- Yes, this plan is replacing an Irish Life plan

C

Yes, this plan is replacing a plan from another life company

C

No, this plan is not replacing another plan

C

Existing Plan Number

Declaration of Insurer / Financial Adviser:

I hereby declare that in accordance with Regulation 6(1) of the Life Assurance (Provision of Information) Regulations, 2001,

Customer's name

[illegible]

Address

[illegible]

Address

[illegible]

has been provided with the information specified in Schedule 1 (Customer Information Notice) to those Regulations and that I have advised the customer as to the financial consequences of replacing an existing plan with this plan by cancellation or reduction, and of possible financial loss as a result of such replacement.



Please sign and date

Signature of Financial Adviser

X	
---	--

Date (dd/mm/yyyy)

		/		/			
--	--	---	--	---	--	--	--

Declaration of Customer:

I confirm that I have received in writing the information specified in the above declaration.



Please sign and date

Signature of Customer

X

Date (dd/mm/yyyy)

			/				/				
--	--	--	---	--	--	--	---	--	--	--	--

B. Plan Declaration

I understand and agree that my contract with Irish Life Assurance plc (Irish Life) will be based on the declarations in this form, my completed application form (online or otherwise), any supplementary questions answered, any statements made to Irish Life in writing or by telephone, any information I give to a medical examiner acting for Irish Life and all terms and conditions given to me by Irish Life. I understand that this contract shall not be capable of being surrendered, commuted or assigned except as provided under Chapter 2 of Part 30 of the Taxes Consolidation Act 1997.

I have read and understand the important information about my obligation to tell Irish Life about all material facts in connection with the application and I understand that if I do not tell Irish Life all material facts, this contract could be void. If this happens, I understand and acknowledge there will be no cover under the plan, Irish Life will not refund my premiums and Irish Life will not pay a claim.

I declare that all information, statements and answers I have provided, including those about tobacco consumption or use of nicotine replacement products including e-cigarettes, are true and complete.

I understand that I must tell Irish Life in writing about any changes in my health, circumstances, or answers to the questions in this application form change between the time I applied for cover and the date my application is accepted.

I understand that this plan will not start until Irish Life has accepted me for cover and I have paid the first payment. I acknowledge that a copy of my application will be sent to me and agree to notify Irish Life, in writing, if:

- I do not receive the printed record
- Any information in this record is, false, incorrect or incomplete

I understand that Irish Life can use my personal information for any subsequent applications to Irish Life.

I authorise Irish Life to request and receive my personal health information now (or as part of any claim assessment including after my death) from any health professional who at any time has attended me concerning my physical or mental health and to share my personal health information with any health professional for the purpose of processing my application and assessing claims.

- I confirm I have read and understood the Medical and Other Important Information section.
- I confirm I have received the product booklet and Customer Information Notice.
- I confirm I have been informed about the Irish Life Data Privacy Notice and where to get this.
- I confirm I have read and understood the Plan Declaration.



Please sign and date

Signature of Customer

X

Date (dd/mm/yyyy)

			/				/				
--	--	--	---	--	--	--	---	--	--	--	--

C. Optional Consent

Consent to Sharing with Other Companies in the Irish Life Group

I agree to Irish Life Assurance sharing my personal information (excluding my personal health information) with other companies within the Irish Life Group, such as Irish Life Health. I understand this is to assist in developing combined customer services (for example, access to services from different Group companies on one online platform). This is an area that will continue to improve with a view to adding new customer engagement offerings.

You can change your mind at any time and opt-out of any further sharing by emailing dataprotectionqueries@irishlife.ie or writing to Irish Life Data Protection Team. If you opt-out we will keep a record of your instruction to opt-out.

Customer

I agree ☐

I don't agree ☐





Your Irish Life Plan Details

Please complete all the fields in this Section

Plan Number(s)

If this mandate is to cover more than 3 plans, please attach separate instructions.

Name of Plan Owner(s)

Direct Debit collection date

 of the month (1st to 28th only)

Payment frequency

Monthly ☐

Quarterly ☐

Half Yearly ☐

Yearly ☐

SEPA DIRECT DEBIT MANDATE

Please complete all the fields below marked * and return this mandate to Irish Life

Name and address of the payer:

* Name(s) of Account Holder(s)

Address of Account Holder(s)

BIC

* IBAN

Your BIC and IBAN can be found on a recent bank statement



* Signature(s)

* Date of signing

Please sign and date

By signing this mandate form, you authorise (A) Irish Life to send instructions to your bank to debit your account and (B) your bank to debit your account in accordance with the instruction from Irish Life. As part of your rights, you are entitled to a refund from your bank under the terms and conditions of your agreement with your bank. A refund must be claimed within 8 weeks starting from the date on which your account was debited. Your rights are explained in a statement that you can obtain from your bank.

For Office Use only

UMR

Creditor Identifier

Type of payment

Recurrent ☒

Creditor's name and address